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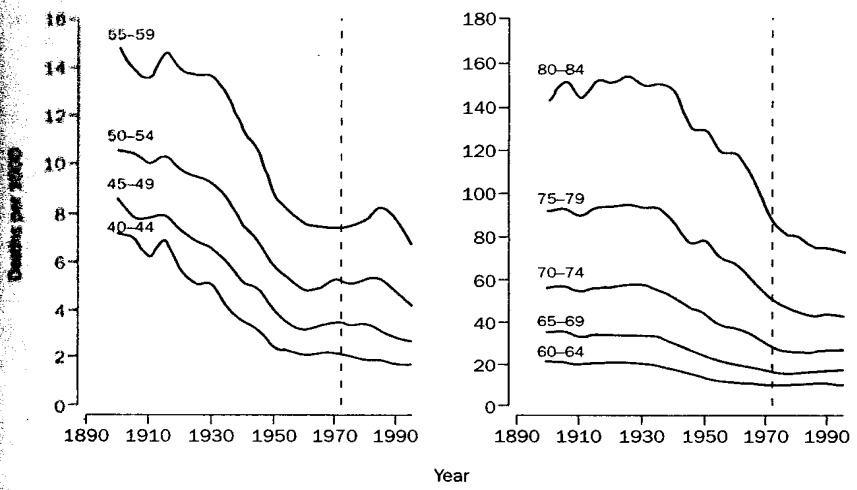

All-cause mortality in Danish women 1900–95 by age-group
Yearly smoothed data. Dashed line shows Queen Margarethe II's ascension to the throne in 1972.

Queen Margrethe II and mortality in Denmark

Sir—Hugo Kesteloot (March 17, p 871)[1] describes the all-cause mortality of women aged 45–74 years in the European Union, Scotland, and Denmark, and speculates on the role-model effect of Queen Margrethe II of Denmark.

If the queen's role-model effect indeed induced the increase in mortality among Danish women, the mortality would be expected to have risen after her ascension to the throne in 1972. The age-specific mortality for Danish women from 1900 to 1995, however, shows that the increase in mortality actually started before 1972 (figure). The curves show an apparent increase in mortality with increasing age. The rise in mortality therefore comes from a certain generation of women.

We suggest a rather more complicated combination of causal factors for the increase in mortality in Danish women than that suggested by Kesteloot, perhaps related to birth cohorts rather than to calendar period. The women with the increase in mortality are the first generations of frequent smokers, but they are also the mothers of the baby-boomers and the generations entering the workforce during the 1960s.

We love our queen, but she is not the only factor controlling our life.

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1 Kesteloot H. Queen Margrethe II and mortality in Danish women. *Lancet* 2001; 357: 871–72

Sir—I believe that Hugo Kesteloot[1] is unscientific to link one person's smoking habits to the mortality in Danish women. I also think that it is unethical and irresponsible of an internationally recognised journal to publish such an insulting item.

The report has aroused displeasure in Denmark. No one will disagree that smoking is unhealthy—the press and prominemt people should support this attitude. However, to castigate one person is undignified.

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1 Keseteloot H. Queen Margrethe II and mortality in Danish women. *Lancet* 2001; 357: 871–72.

PPARγ agonists for intestinal ischaemia

Sir—Despite an increased awarenes of ischaemia-reperfusion injury and substantial progress in the management of this disorder, it remains important in acute mesenteric ischaemia, small-bowel transplantation, and necrotising enterocolitis. Antispasmodics, analgesics, antibiotics, or vasodilators are sometimes used palliatively to treat patients with intestinal ischaemia, but they do not effectively prevent or reverse the intestinal injury.

Peroxisome proliferator-activated receptor γ (PPARγ) is a nuclear receptor that was originally shown to play a critical role in adipocyte differentiation and insulin sensitivity.[1] Later evidence has shown the potential role of PPARγ in regulating colonic inflammation through the use of the agonistic ligands for PPARγ.[2] We have noted that these ligands effectively inhibit intestinal injury in a mouse model of ischaemia and reperfusion.[3] We have also found PPARγ ligand therapy to be very effective in a patient with intestinal ischaemia.

The patient was a woman aged 52 years with retroperitoneal fibrosis due to long-term abuse of non-steroidal anti-inflammatory drugs.[4] 8 years previously, radiological examinations had shown that the main trunk of her portal vein was occluded by the fibrosis. She had been given diuretics for mild ascites and oedema due to portal hypertension, and had had four episodes of mild abdominal pain that were thought to be due to mild intestinal ischaemia. She presented to us with sudden-onset severe abdominal pain. Antispasmodics and pentazocine did not relieve the pain. 3 h later, she passed a small amount of bloody stool. Emergent computed tomography with contrast enhancement revealed thickening of the mesentery and decreased enhancement of the ascending and transverse colon, which was more prominent than in previous assessments. She was diagnosed with intestinal ischaemia and given a 15 mg tablet of pioglitazone, a PPARγ ligand, with the patient's informed consent. The severe abdominal pain subsided within 1 h. We administered 15 mg pioglitazone daily for 10 days Her oedema increased slightly during the treatment period, but did not require an increase in the dose of diuretics.

The precise mechanisms of the tissue-protecting effect of PPARγ agonists in intestinal ischaemia-reperfusion injury are unknown, but they involve inhibition of NF-kB activation, followed by decreased expression of inflammatory molecules, including proinflammatory cytokines and adhesion molecules, in injured tissues.[3] Experimental colitis in rodents is ameliorated by PPARγ ligands,[2] and a clinical trial to treat patients with ulcerative colitis with a PPARγ ligand is underway.[5] Our results, however, strongly suggests that PPARγ agonists are useful in the treatment of intestinal ischaemia.

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Meningococcal disease due to strain W135

Sir—Since 1992, we have managed more than 700 children with meningococcal disease. Last year, we reported four cases of Hajj-related serogroup W135 meningococcal disease.[1] After this year's Hajj in March, we admitted a further six paediatric patients with meningococcal W135 infection (three were confirmed Type A, P1.2, 1.5, the Hajj-related serogroup), two of whom died.

Each year, more than 1 million Muslim pilgrims travel to Mecca for the Hajj, around 20 000 from the UK. Last year, the Public Health Laboratory Service (PHLS) reported in the UK an outbreak of Hajj-related W135 meningococcal infection. Cases continued to be reported 9 months after the Hajj, which suggests sustained transmission of the strain.[2] A similar pattern has followed this year's Hajj pilgrimage.

This year, the UK Department of Health recommended the quadrivalent meningococcal polysaccharide vaccine, which provides protection against strains A, C, W135, and Y, for all pilgrims travelling for Hajj or Umrah. Despite the recommendations being distributed to health-care professionals and the Muslim community, the estimated uptake of the vaccine for this year's pilgrimage was less than 50%.[3] No pilgrim contact of our admissions this year had been vaccinated with the quadrivalent vaccine. The higher personal cost (UK£17.14, excluding value added tax) compared with the previously recommended A and C polysaccharide vaccine (£6.39), and the fact that travel to Saudi Arabia, until recently, required only a certificate of vaccination against A and C strains, may well have contributed to this situation. Cost remains an issue for future consideration.

Although the manufacturers report 50–85% seroconversion against serogroup W135, the polysaccharide vaccine might not affect nasopharyngeal carriage.[4] Therefore, secondary cases of W135 meningococcal infection could still occur in the UK, despite quadrivalent vaccination. Even if travellers have been vaccinated with the polysaccharide vaccine, contacts should be made aware of the possibility of contracting meningococcal disease.

In the USA, the quadrivalent vaccine is routinely administered to travellers to Saudi Arabia. A recent US study reported that around 1% of returning Hajj pilgrims became W135 carriers.[4] Because of the low rate of serogroup W135 carriage, antimicrobial chemoprophylaxis was not recommended. Currently, there are no UK data on changes in nasopharyngeal carriage rates in returning pilgrims. Similar studies in the UK could alter future recommendations.

Maiden and colleagues[5] suggest that, after the introduction of meningococcal C vaccine in the UK, the epidemiological niche created might be occupied by hypervirulent strains of meningococci, including W135. Small changes in carriage of hypervirulent strains might greatly affect disease rates. With the theoretical risk of other serogroups becoming more prevalent as meningococcal C disease is controlled, continued clinical, laboratory, and epidemiological vigilance would be prudent throughout the year.

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Implications of prelingual deafness

Sir—Johannes Borgstein questions "What is worse . . . to be blind or to be deaf?" (March 31, p 1036).[1] When we became aware that our son was deaf, our first response, as overeducated parents, was to read every book and article that we could locate.

There are a few essential facts that surround the issue of prelingual deafness: more than 90% of prelingually deaf children are unlikely to ever develop good speech and good speech-reception skills, despite being fitted with hearing aids and provided with oral instruction and speech therapy at a young age; without developing a strong language base before age 10 years, deaf people are unlikely to develop and use abstract concepts, and, despite about 90% of deaf children being raised orally, most end up using sign language as adults.

One additional fact we found was that the group of deaf children who were most likely to attain high reading levels and graduate from college were, in fact, the children whose parents were themselves deaf.

What is the difference for these children? Although they are isolated from sound and from speech, they are not isolated from language.

I think that commonly, the real issue is one of attitude. I do not see us tormenting the blind to read small print or to take painting classes and then bemoaning the fact that they have failed and are, therefore, missing an essential part of human existence. So why do we take such a narrow attitude toward the deaf and how they must be educated, as well as assessing their ability to learn in light of that method? We would certainly not compare a blind person who could not differentiate between navy blue and aquamarine and the level of existence of a chimpanzee. This attitude is nothing more than bigotry.

I agree that to be without language is devastating, the definition of language that Borgstein has chosen blatantly ignores that American Sign Language has been designated a true language—and one that is easily accessible to the deaf, in the same way that spoken language is accessible to the hearing. We do not ask blind children to navigate through unfamiliar buildings using their eyesight, their weakest sense. Nor do we ask children who do not have legs to get up and walk across a campus and up the steps to the schoolroom, yet many people seem to think it reasonable to ask deaf children to learn primarily through their weakest sense.

"Hearing is the basis of our human existence." That is a denial of the fact that long before hearing aids and oral schools were opened in the USA, a large group of deaf people, in Martha's Vineyard, MA, achieved noticeable success in their community, even becoming leaders of the hearing community. Nor does this premise explain how many deaf who have never had speech or the benefit of hearing can learn and become fluent in multiple languages, as Laurent Clerc did, learning English (written form) on the boat trip to the USA.

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